JOINT
BUDGET
COMMITTEE

STAFF BUDGET BRIEFING
FY 2020-21

HEALTH INSURANCE PUBLIC OPTION AND REINSURANCE

(Department of Regulatory Agencies, Division of Insurance and Department of Health Care Policy and Financing)

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

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INTRODUCTION

The public option and reinsurance programs are two different strategies to address the same issue, lowering premiums for the individual health insurance market. Both programs can be utilized at the same time for a compounding impact on premium prices, and may also have a compounded impact on hospitals, with increased fees and decreased reimbursement rates. Currently, the reinsurance program is operating under a two year approval and is slated to end in December 2021, with the proposed public option taking effect in 2022, so no overlap is expected. If the reinsurance program is extended however, both programs can operate at the same time independently of each other.

ISSUE: PUBLIC OPTION HEALTH INSURANCE

The Department of Regulatory Agencies' Division of Insurance and the Department of Health Care Policy and Financing have collaborated to present a recommendation on how the State of Colorado should pursue a public option for health insurance coverage. The plan takes a public-private partnership approach that will require private insurance carriers to provide public option plans approved by the State.

SUMMARY

- The final recommendation from the Department of Health Care Policy and Financing and the Division of Insurance is anticipated to offer health insurance plans on the individual market with premium rates anywhere from 8 to 17 percent lower than current offerings.

- Public option plans will utilize a higher medical loss ratio by insurance companies, pharmaceutical rebates, and a hospital rate setting formula in order to make the plans more affordable.

- The proposed plan will require changes to statute in the upcoming session, including the ability to mandate carrier and provider participation, the ability to implement benefit design and rate setting, and the creation of a new advisory board.

- A newly created advisory board will advise DOI and HCPF on significant policy issues relating to the public option, but ultimately decision making authority will rest with the State.

DISCUSSION

BACKGROUND (HB19-1004)

During the 2019 legislative session the General Assembly passed HB 19-1004: Proposal for Affordable Health Care Options. The bill required the Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA) and the Department of Health Care Policy and Financing (HCPF) to develop and submit a proposal for a public option for health insurance coverage. The proposal was required to consider the following:

- Leveraging of Colorado's existing health care infrastructure
- Affordability for consumers across different income levels
- Statutory changes necessary to implement the proposed plan
- Administrative and financial burdens to the State

House Bill 19-1004 also required the DOI and HCPF to participate in a stakeholder engagement process in the development of the final report. In accordance with legislation, 20 public stakeholder meetings were held and over 260 public comment letters were received.

OVERVIEW OF PUBLIC OPTION FINAL REPORT TO GENERAL ASSEMBLY

The final recommendation from both DOI and HCPF is that public option plans should be administered by private insurance companies, rather than the State. In this public-private partnership, private insurers would provide the State approved plans alongside their more traditional plans on the open individual market.

By administering the public option through regulatory tools placed on existing insurance carriers, rather than administering a State run plan through expanded Medicaid infrastructure, the State will not bear any of the financial risk associated with the plans. The Governor's FY 2020-21 budget request does include $1.0 million for the initial administration of the public option. This request includes funding to submit a federal 1332 waiver, administer the proposed advisory board, and perform data connectivity buildouts for carriers administering public option plans. A similar, but smaller, amount will be needed annually for DOI and HCPF to administer the program in ongoing years.

The State Option plan recommended by DOI and HCPF will initially be available to all Coloradans on the individual market, both on and off the statewide health exchange (Connect for Health Colorado) beginning in the 2022 plan year. In the first year the public option plans are made available, the Departments anticipate an increase of roughly 5,700 people participating in the individual market, with that number expected to grow in subsequent years. The new additions to the market are expected to be individuals who were previously uninsured.

Benefit designs under public option plans will be developed based on recommendations by the newly created advisory board, but will cover at minimum the health benefits established by the Affordable Care Act. These benefits will include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition to essential health benefits, the public option plans are anticipated to make more services available pre-deductible in order to incentivize more consumers to utilize the health care system.

PREMIUM REDUCTIONS

Based on an actuarial analysis by Wakely Consulting Group, public option plans across the state are expected to be offered at premium rates anywhere from 7.8 to 16.9 percent lower than projected standard qualified health plan premiums. DOI and HCPF recommend three stratagies to achieve these direct savings to the consumer;

- Raising the medical loss ratio (MLR) of insurance carriers from 80 percent to 85 percent
- Requiring that compensation from perscription drug manufacturers, such as rebates, be applied to consumer premium price price reductions or enhanced benefits
- Setting reimbursement rates for hospitals

RAISING THE MEDICAL LOSS RATIO

The Affordable Care Act requires that 80 percent of all premium revenue collected by an insurance carrier be spent on patient care, leaving 20 percent to be used for both administrative purposes and profit margins. This is known as the medical loss ratio or MLR. The HCPF and DOI recommendation is that for the public option plans being offered, this MLR be raised from 80 percent to 85 percent, while traditional plans will be able to continue to operate at an 80 percent rate. Insurance carriers' MLRs are calculated on a three year average and some operate at a voluntary MLR higher than 80 percent, making the actual amount of savings from this mechanism difficult to calculate. In the Wakely actuarial analysis, the change in MLR rate was assumed to be immaterial and did not have a significant impact on premium rates.

PHARMACEUTICAL REBATES

A rebate is the return of part of the purchase price from the seller to the buyer. Insurance carriers may receive rebates from drug manufactures to encourage the use of a particular drug, which in turn can promote the utilization of higher priced drugs. The DOI and HCPF recommendation will require all compensation from prescription drug manufacturers to be redistributed to the consumer, either through premium reduction or benefit design. Beginning in October of 2018, insurance carriers are required to disclose all prescription drug manufacturer payments on their insured business to the Colorado All Payer Claims Database. Analysis of that data is expected by the end of March 2020, but was not figured into the actuarial analysis on premium reduction.

SETTING HOSPITAL REIMBURSEMENT RATES

The estimated premium reductions outlined above were calculated under the assumption that facility reimbursement rates would be set as a percentage of what Medicare would reimburse for the same service, somewhere between 160 and 210 percent. As a comparison, the statewide average price in relation to Medicare in 2017 was 269 percent, but also varied wildly from hospital to hospital. For example, according to a RAND study using 2015-2017 data, Wray Community District Hospital registered net reimbursement rates at 121 percent of Medicare while the Valley View Hospital Association in Glenwood Springs showed net reimbursement rates at a reported 399 percent.

While initially proposing that reimbursement rates for public option plans be expressed as a percentage of Medicare rates, the final recommendation seeks to develop a reimbursement formula that will be hospital specific and change with advisory board input over time. The reimbursement formula has not been developed as of the writing of this issue brief, but is expected to take into account factors like:

- Administrative costs compared to national averages
- Profit margins and accumulated earnings
- Hospital classification (rural, urban, system owned, independent, critical access)
- Payer mix

By utilizing a formula that takes these factors into account, the DOI and HCPF are hoping to help, and not hinder, rural hospitals. Many rural hospitals have payer mixes that include higher percentages of patients who are eligible for Medicare and Medicaid, which reimburse at lower rates. This also means that rural hospitals tend to operate at much lower profit margins than their more urban counterparts. A flexible hospital specific formula will allow DOI and HCPF to set reimbursement rates higher at rural facilities.

VALUE BASED PAYMENTS

There have been significant efforts over recent years by both public and private health insurance carriers to move away from a fee for service payment structure towards one that pays for value over volume. Value based payment structures are used to incentivize providers to keep their populations healthy and to keep their costs down. Two common approaches to paying providers differently are capitated payment models and bundled payments.

Capitated payments pay providers a monthly amount for each patient they have attributed to them, and generally vary in amount depending on the patient population. Healthier patients generally cost less, so the provider has an incentive to provide preventative services to improve and maintain patient population health. There can also be extra incentives for the provider if they report health related metrics to the insurance carrier.

Bundled payments have similar goals, and are more often thought of when referring to specialty care. In this model, carriers will pay providers a lump sum for a specific episode of care. In the example of a surgical procedure the provider will be responsible not only for the procedure, but for any after-care the patient may need as well. If the total costs for the patient's episode are less than the amount allowed by the carrier, the provider keeps the remaining funds.

The DOI and HCPF recommendation puts significant emphasis on the use of value based payments in driving market costs over time, and implementing these models into the public option. The actuarial analysis done on this proposal shows that costs and savings relating to value based payments will offset in the initial years, resulting in no impact on premium rates.

FEDERAL 1332 WAIVER

A federal 1332 waiver is not required for the implementation of this plan, but could be utilized to allow for federal funding to enter the state market. If approved, a 1332 waiver would allow the federal government to calculate the amount of money being saved by distributing less in federal subsidies on the exchange. If approved, funding equal to the amount of savings in federal subsidies would be redirected to the State. The actuarial analysis estimates this amount to be around $89 million. How these federal funds would be used has not been determined, but it is anticipated that funding would would be directed to people on the individual market with incomes under 400 percent of the federal poverty level.

COST SHIFTING

One argument against the implementation of a public option is that of cost shifting. Cost shifting in healthcare is when a hospital charges one population more to compensate for another. This can be thought of as when a facility charges private insurance carriers more because of uncompensated care

they are providing for the uninsured population, or to make up for low Medicare and Medicaid reimbursement rates.

The concern is that by setting hospital reimbursement rates for public option plans at a level below plans currently on the individual market, facilities will shift costs to either other plans on the individual market, to the small and large group markets, or find other ways to recoup those dollars. In terms of hospitals being able to recuperate those dollars in other areas of the private insurance market, the legislature passed H.B. 19-1233 last year, which requires the Commissioner of Insurance to set affordability standards under Section 10-16-107 (3.5), C.R.S. This, along with the statutory authority already granted to the Commissioner in Section 10-16-107, C.R.S., to monitor and approve rate increases, will allow DOI to disapprove plans seen as not meeting affordability standards and may be used as a tool to regulate cost shifting in the private insurance market.

REGULATORY AUTHORITY NEEDED TO IMPLEMENT RECOMMENDATION

STATUTORY AUTHORITY

The DOI and HCPF recommended plan requires statutory changes to expand the authority of the Commissioner of Insurance, and to create an advisory board. In order for the public option plans to have an effect on premium reductions, there must both be private insurers to offer the plans, and providers and facilities to accept them. The Commissioner is seeking several regulatory tools relating to insurance carriers:

- Require each insurance carrier offering a plan in an individual market area to offer a public option plan.
- Require the public option plans being offered to meet a certain benefit design and premium rates.
- If a market area only has one carrier on the individual market, authorize the Commissioner to require another carrier to enter that same market.

In order for public option plans to be useful to the consumer, there must be a provider network that accepts that coverage. To ensure this, the Commissioner of Insurance will be requesting the authority to require provider acceptance of the public option plan.

GOVERNANCE STRUCTURE

The DOI and HCPF recommendation includes the creation of an advisory board to advise DOI and HCPF on significant policy issues relating to the public option including: plan rates, value based payments, affordability, benefit design, and out of pocket costs for the consumer. Members of the advisory board are expected to be from diverse backgrounds and industries, including urban and rural hospitals, insurance carriers, consumer advocacy groups, and regional representatives. Ultimately the decision making authority, as outlined in the final report, rests with DOI and HCPF. Staff recommends that the General Assembly consider statutory guardrails when drafting legislation relating to the public option plan. Guardrails may include an avenue for providers or carriers to appeal Commissioner of Insurance decisions on rate setting and market entry to a separate regulatory entity.

ISSUE: REINSURANCE

The Governor requests $60.0 million more General Fund for the reinsurance program authorized by H.B. 19-1168. With the request and changes in the forecast, the General Fund impact of reinsurance is estimated at $184.6 million, or $164.5 million more than the $20.1 million dollar impact identified in the Legislative Council Staff Fiscal Note for the bill.

SUMMARY

- The Governor requests $60.0 million more General Fund for reinsurance, including:
  - $18.4 million to maintain the reductions in insurance premiums targeted in statute in 2021
  - $41.6 million to prepay for year three, create a path to enterprise status, and create a contingency

- With the Governor's request and changes in the forecast, the General Fund impact of reinsurance is estimated at $184.6 million, or $164.5 million more than the $20.1 million dollar impact identified in the Legislative Council Staff Fiscal Note for the bill.

- Rejecting the Governor's request and passing legislation to minimize the TABOR consequences of reinsurance could reduce the General Fund impact by $113.3 million to $71.3 million, but this scenario would decrease the insurance premium savings achievable in 2021.

- Legislation to provide the least possible funding to maintain the insurance premium savings in 2021 and minimize the TABOR consequences could reduce the General Fund impact by $81.6 million to $103.0 million.

- Reinsurance achieved the targeted reductions to insurance premiums in 2020, but the interaction of the program with federal tax credits for people earning less than 400 percent of the federal poverty guidelines caused some people to be worse off if they wanted to buy the same plan.

- For an equivalent investment of state funds, the legislature may want to consider whether a more narrowly targeted program at people earning more than 400 percent of the federal poverty guidelines would be beneficial.

DISCUSSION

OVERVIEW

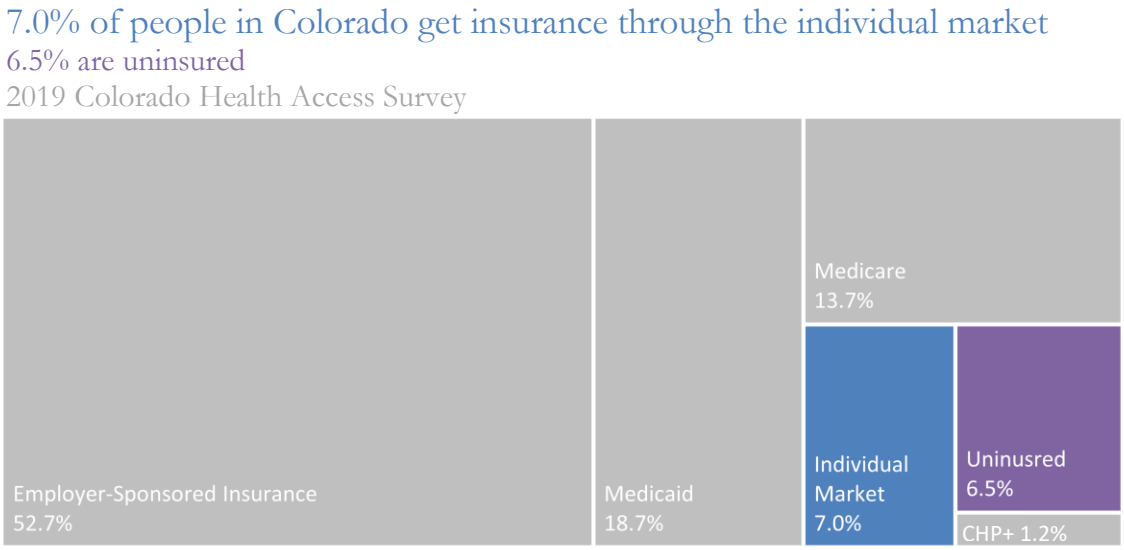
The Governor requests that the JBC sponsor a bill to add $60.0 million General Fund to the reinsurance program authorized by H.B. 19-1168 (McCluskie & Rich/Donovan & Rankin). When H.B. 19-1168 was passed, the estimated General Fund impact was $20.1 million cumulative over the two plan years (calendar year 2020 and 2021) that the program was authorized. With changes in the revenue forecast and the additional money requested by the Governor, the General Fund impact is now projected to be $184.6 million, or $164.5 million more than originally expected.

It is important to understand that most of the increased General Fund impact is attributable to a new revenue forecast that changes the way the state revenue sources identified for the program interact with the TABOR refund obligation. This accounts for $95.0 million of the total increase. Another $9.5 million is attributable to a higher forecast of insurance premium taxes. The remaining $60.0 million is due to the Governor's request.

EXPLANATION OF REINSURANCE

Reinsurance is insurance for insurance providers. If a client of an insurance company incurs medical costs above a threshold, then the reinsurance pays the insurance company for those costs, up to a capped amount. By removing some of the risk from insurance providers for high cost clients, reinsurance can effectively buy down the premiums the insurance providers charge to cover their risk.

The reinsurance program only applies to the individual market, which represents approximately 7.0 percent of the Colorado population. The most recent actuarial analysis projected enrollment in calendar year 2020 through the individual market would be 216,795 without the reinsurance program. With the reinsurance program the actuary projects an additional 6,378 who are currently uninsured will enroll in the individual market. This projected 2.9 percent increase in enrollment brings the expected individual market enrollment to 223,173.



House Bill 19-1168 set targets for the reduction in insurance premiums by region. The table below summarizes the targeted reductions from the bill and the actual reductions reported by the Division of Insurance.

Insurance Premium Targeted Reductions	
Region	Reduction
Largest targeted reductions	30-35%
Region 5 (Grand Junction) actual	28.2%
Region 9 (West) actual	30.0%
Middle targeted reductions	20-25%
Region 4 (Ft. Collins) actual	21.7%
Region 6 (Greeley) actual	20.8%
Region 7 (Pueblo) actual	22.8%
Region 8 (East) actual	27.7%
Lowest targeted reductions	15-20%
Region 1 (Boulder) actual	17.0%
Region 2 (Colorado Springs) actual	17.6%
Region 3 (Denver) actual	17.9%

REVENUE SOURCES

The revenue to pay for reinsurance comes from an assessment on hospitals, transfers from the General Fund, a reallocation of insurance premium taxes, and federal funds.

- Hospital Assessment – The bill allowed fees on hospitals of up to $40.0 million per year in calendar year 2020 and 2021. The fees come from a gap between a federal upper payment limit on how much Medicaid can reimburse hospitals through the Healthcare Affordability and Sustainability (HAS) fee and a federal provision that limits state assessments on hospitals to six percent of net patient revenues. If the gap is less than $40.0 million in a given year, the Division of Insurance must reduce the amount collected. The Department of Health Care Policy and Financing is confident that there will be enough of a gap to collect the full $40.0 million in 2020, but whether there will be a $40.0 million gap in 2021 is still a rough projection. Historically, there have been large fluctuations from one year to the next in both the upper payment limit and the six percent of net patient revenues limit.
- General Fund Transfers – The bill transferred a total of $55.0 million General Fund to the reinsurance program. The transfers were contingent on the passage of H.B. 19-1245 that provided an offsetting increase in General Fund revenue through adjustments to the vendor fee.
- Insurance Premium Taxes – The bill reallocated a portion of insurance premium taxes from the General Fund to reinsurance in FY 2020-21 and FY 2021-22. The amount reallocated each year is equal to the increase in insurance premium taxes that occurred from 2019 to 2020. In addition, administering the bill is expected to cost $3.0 million in insurance premium taxes that would otherwise flow to the General Fund after a temporary stay in the Division of Insurance Cash Fund.
- Federal Funds – By reducing premiums reinsurance reduces the federal obligation for tax credits that help people between 400 percent and 100 percent of the federal poverty guidelines (FPL) buy insurance on the health care exchange. The projected federal funds that would otherwise be spent on tax credits are passed through to the state to help pay for the reinsurance program.

How the Overall Financing has Changed

The tables below show the assumptions about the financing of H.B. 19-1168 that were used for the Legislative Council Staff (LCS) Fiscal Note and the request from the Governor's office.

It is important to note that the LCS Fiscal Note projected that the funding provided in the bill would be $149.6 million total funds, including $53.8 million from state sources, short of the amount necessary to achieve the reductions in insurance premiums targeted in statute. In the event of insufficient revenues, the bill permitted the executive branch to do less than the targeted reductions to insurance premiums. The LCS Fiscal Note assumed the funding provided in the bill would be sufficient to achieve only 75 percent of the targeted reductions to insurance premiums.[1]

In the request the Governor projects an additional $9.5 million in insurance premium taxes, but with this increase there would still be a deficit of $18.4 million to achieve the reductions in insurance premiums targeted in statute, and so the total increase from state sources needed to fully fund the targeted reductions to insurance premiums is $27.9 million ($9.5 million + $18.4 million). This is less than the $53.8 million deficit in funding from state sources that was projected in the LCS Fiscal Note.

Of the $60.0 million General Fund the Governor requests, $18.4 million is to close the deficit in funding needed to maintain the reductions in insurance premiums that were targeted in statute through 2021. Without this money the buy down of premiums in 2021 would be roughly 20 percent less than the buy down achieved in 2020. The Governor's office describes the purpose of the remaining request for $41.6 million General Fund as prepaying for year three, creating a path to enterprise status, and creating a contingency against revenue and expense uncertainty. Extending the program to a third or more years would require legislation. The Governor did not include legislation to extend the program as part of the budget request, but a bill to extend the program could be introduced during either the 2020 or 2021 legislative session.

Financing of HB 19-1168 Reinsurance Program - LCS Fiscal Note					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	Cumulative
Beginning Balance	$0	$86,527,500	$318,132,500	$219,105,000	
Revenue					
Hospital assessment	0	40,000,000	40,000,000	NA	80,000,000
General Fund transfers	15,000,000	40,000,000	0	NA	55,000,000
Insurance premium taxes	0	8,550,000	8,550,000	NA	17,100,000
DOI Cash Fund for admin	836,200	1,082,184	1,082,184	NA	3,000,568
Subtotal - State Sources	*15,836,200*	*89,632,184*	*49,632,184*	*0*	*155,100,568*
Federal Funds	71,527,500	143,055,000	71,527,500	NA	286,110,000
Total - Revenue	**$87,363,700**	**$232,687,184**	**$121,159,684**	**$0**	**$441,210,568**
Expenditures					
Reinsurance payments	0	0	219,105,000	219,105,000	438,210,000
Administration	836,200	1,082,184	1,082,184	NA	3,000,568
Total - Expenditures	**$836,200**	**$1,082,184**	**$220,187,184**	**$219,105,000**	**$441,210,568**
Ending Balance	$86,527,500	$318,132,500	$219,105,000	$0	

[1] See the discussion of Reinsurance Payments on page 5 of the LCS Fiscal Note: http://leg.colorado.gov/sites/default/files/documents/2019A/bills/fn/2019a_hb1168_f1.pdf

With Governor's Request					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	Cumulative
Beginning Balance	$0	$215,000,000	$488,300,000	$291,600,000	
Revenue					
Hospital assessment	40,000,000	0	40,000,000	0	80,000,000
General Fund transfers	15,000,000	40,000,000	0	0	55,000,000
Governor's Request	0	60,000,000	0	0	60,000,000
Insurance premium taxes	0	13,300,000	13,300,000	0	26,600,000
DOI Cash Fund for admin	836,200	1,082,184	1,082,184	0	3,000,568
Subtotal - State Sources	*55,836,200*	*114,382,184*	*54,382,184*	*0*	*224,600,568*
Federal Funds	160,000,000	160,000,000	0	0	320,000,000
Total - Revenue	**$215,836,200**	**$274,382,184**	**$54,382,184**	**$0**	**$544,600,568**
Expenditures					
Reinsurance payments	0	0	250,000,000	250,000,000	500,000,000
Administration	836,200	1,082,184	1,082,184	0	3,000,568
Total - Expenditures	**$836,200**	**$1,082,184**	**$251,082,184**	**$250,000,000**	**$503,000,568**
Ending Balance	$215,000,000	$488,300,000	$291,600,000	$41,600,000	

HOW THE GENERAL FUND IMPACT HAS CHANGED

House Bill 19-1168 included provisions to mitigate the General Fund impact and reduce the net effect on the General Fund budget to $20.1 million. Based on the OSPB and LCS revenue projections, those strategies are no longer effective in mitigating the General Fund impact. The change in the revenue projections combined with the additional money the Governor proposes adding to the program increases the General Fund impact to $184.6 million.

One of the strategies H.B. 19-1168 employed to mitigate the General Fund impact was to tie the cost of the General Fund transfers to an offsetting increase in General Fund revenues due to changes in the sales tax vendor fee accomplished through H.B. 19-1245. At the time reinsurance was adopted, the revenue projections showed statewide revenues would be below the TABOR limit, and so the additional revenue from the vendor fee had no impact on the TABOR refund obligation. However, under the current OSPB and LCS revenue projections the increase in revenues from the vendor fee contributes to a larger TABOR refund obligation that will be paid from the General Fund.

The second strategy H.B. 19-1168 employed to mitigate the General Fund impact was to designate the reinsurance program as an enterprise with revenues that are exempt from TABOR *in any year it receives less than 10 percent of revenues from state and local grants*. There is a misconception that this made the revenue from the hospital assessment exempt from TABOR, but that is not entirely accurate. The reinsurance program was never projected to achieve enterprise status in FY 2020-21. The LCS Fiscal Note for H.B. 19-1168 projected the revenue from the hospital assessment would not increase the TABOR refund obligation because the LCS March revenue forecast projected there would be no TABOR refund obligation. However, based on the current OSPB and LCS revenue projections there will be a TABOR refund obligation in FY 2019-20 through FY 201-22 and some of the revenue from the hospital assessment will contribute to a larger TABOR refund obligation that will be paid from the General Fund.

The Governor plans to move $40 million of the revenue from the hospital assessment from FY 2020-21, when it would contribute to an increased TABOR refund obligation, to FY 2019-20, when the reinsurance program is expected to meet the enterprise criteria. This shift in timing can be

accomplished within the existing statutory authority for the reinsurance program. The remaining $40 million from the hospital assessment is currently projected to contribute to an increased TABOR refund obligation in FY 2021-22.

If the reinsurance program were extended another year to 2022, then there would be another roughly $160 million in federal funds in FY 2021-22 and the reinsurance program could qualify for enterprise status in that year. However, the current structure of the reinsurance program is projected to require $91.5 million state funds per year. The Governor's proposal to prepay $41.6 million would leave a remaining deficit of $49.9 million state funds for 2022. As noted previously, it is difficult to project whether the hospital assessment is a viable potential source of revenue for an extension of the program to 2022 or beyond, as there have been large fluctuations historically from one year to the next in the parameters that determine whether there is room within federal limits to collect the hospital assessment. Also, the Governor's public option proposal would be financed from hospitals, compounding the financial impact on these providers.

The tables below summarize how the projected General Fund impact of reinsurance has changed since the assumptions used for the LCS Fiscal Note.

General Fund Impact of HB 19-1168 and Related Portions of HB 19-1245 - LCS Fiscal Note				
	FY 2019-20	FY 2020-21	FY 2021-22	Cumulative
General Fund Revenue				
Vendor fee (related portion of HB 19-1245)	$15,000,000	$40,000,000	$0	$55,000,000
Diversion of insurance premium taxes to reinsurance	0	(8,550,000)	(8,550,000)	(17,100,000)
Revenue from DOI Cash Fund	(836,200)	(1,082,184)	(1,082,184)	(3,000,568)
Subtotal - Revenue	**$14,163,800**	**$30,367,816**	**($9,632,184)**	**$34,899,432**
General Fund Expenditures				
Transfers to Reinsurance Program Cash Fund	$15,000,000	$40,000,000	$0	$55,000,000
TABOR obligation vendor fee (LCS March)	0	0	0	0
TABOR obligation Hospital assessment (LCS March)	0	0	0	0
Subtotal - Expenditures	**$15,000,000**	**$40,000,000**	**$0**	**$55,000,000**
Net General Fund Impact	**$836,200**	**$9,632,184**	**$9,632,184**	**$20,100,568**

General Fund Impact of HB 19-1168 and Related Portions of HB 19-1245 - Governor's Request				
	FY 2019-20	FY 2020-21	FY 2021-22	Cumulative
General Fund Revenue				
Vendor fee (the related portion of HB 19-1245)	$15,000,000	$40,000,000	$0	$55,000,000
Diversion of insurance premium taxes to reinsurance	0	(13,300,000)	(13,300,000)	(26,600,000)
Revenue from DOI Cash Fund	(836,200)	(1,082,184)	(1,082,184)	(3,000,568)
Subtotal - Revenue	**$14,163,800**	**$25,617,816**	**($14,382,184)**	**$25,399,432**
General Fund Expenditures				
Transfers to Reinsurance Program Cash Fund	$15,000,000	$40,000,000	$0	$55,000,000
TABOR obligation vendor fee (OSPB Sept)	15,000,000	40,000,000	0	55,000,000
TABOR obligation Hospital assessment (OSPB Sept)	0	0	40,000,000	40,000,000
Governor Requested additional General Fund transfer	0	60,000,000	0	60,000,000
Subtotal - Expenditures	**$30,000,000**	**$140,000,000**	**$40,000,000**	**$210,000,000**
Net General Fund Cost	**$15,836,200**	**$114,382,184**	**$54,382,184**	**$184,600,568**

The Governor's Office of State Planning and Budgeting (OSPB) has a somewhat different perspective on the change in the General Fund impact than the JBC staff. Both offices agree that the majority of the change in the General Fund impact is attributable to a new revenue forecast. OSPB argues that the changes attributable to the forecast are, therefore, "unrelated to reinsurance." The money earmarked for reinsurance is the first money in the door and any increase in the TABOR refund obligation is due to the overall forecast going up, rather than reinsurance, according to OSPB. The JBC staff comes at the analysis from a different angle. Absent reinsurance, the state would not need these revenue streams that are financing reinsurance and contributing to the TABOR refund obligation, or the revenue streams would be attributed to a different program (such as affordable housing, which might have been the case with the vendor fee).

MITIGATING THE GENERAL FUND IMPACT

There are several potential strategies for mitigating the General Fund impact of the reinsurance program. This JBC staff analysis discuses two strategies.

SCENARIO 1 – REJECT GOVERNOR'S REQUEST AND REDUCE PREMIUM SAVINGS

If the General Assembly is comfortable with lower insurance premium savings, the Governor's request could be rejected. As noted previously, the LCS Fiscal Note identified that H.B. 19-1168 was never funded sufficiently to achieve the targeted reductions to insurance premiums in the statute. In this scenario, it would also make sense to run a bill to eliminate the $13.3 million diversion of insurance premium taxes to reinsurance in FY 2021-22 to allow reinsurance to qualify for enterprise status in that year. Rejecting the Governor's request would save $60.0 million, eliminating the diversion of insurance premiums would save $13.3 million, and qualifying for enterprise status would save $40.0 million, reducing the total General Fund impact by $113.3 million relative to the Governor's request.

In this scenario, the funding from state sources in 2021 would be about $31.7 million, or 35 percent, short of the roughly $91.5 million needed annually to achieve the reductions in insurance premiums targeted in statute. Since the federal funding changes roughly in proportion with the state funding, this means the reductions in insurance premiums would likely be in the range of 35 percent less than the reductions targeted in statute to live within the provided resources in 2021.

In the tables below no attempt was made to update the federal funds, in order to highlight the changes to state funding sources, but the federal funds would change roughly in proportion to the deficit in state funding.

Scenario 1 - Mitigating the General Fund Impact					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	Cumulative
Beginning Balance	$0	$215,000,000	$428,300,000	$218,300,000	
Revenue					
Hospital assessment	40,000,000	0	40,000,000	0	80,000,000
General Fund transfers	15,000,000	40,000,000	0	0	55,000,000
Governor's Request	0	0	0	0	0
Insurance premium taxes	0	13,300,000	0	0	13,300,000
DOI Cash Fund for admin	836,200	1,082,184	1,082,184	0	3,000,568
Subtotal - State Sources	*55,836,200*	*54,382,184*	*41,082,184*	*0*	*151,300,568*
Federal Funds	160,000,000	160,000,000	0	0	320,000,000
Total - Revenue	**$215,836,200**	**$214,382,184**	**$41,082,184**	**$0**	**$471,300,568**
Expenditures					
Reinsurance payments	0	0	250,000,000	250,000,000	500,000,000
Administration	836,200	1,082,184	1,082,184	0	3,000,568
Total - Expenditures	**$836,200**	**$1,082,184**	**$251,082,184**	**$250,000,000**	**$503,000,568**
Ending Balance	$215,000,000	$428,300,000	$218,300,000	($31,700,000)	

General Fund Impact of HB 19-1168 and Related Portions of HB 19-1245 - Scenario 1				
	FY 2019-20	FY 2020-21	FY 2021-22	Cumulative
General Fund Revenue				
Vendor fee (related portion of HB 19-1245)	$15,000,000	$40,000,000	$0	$55,000,000
Diversion of insurance premium taxes	0	(13,300,000)	0	(13,300,000)
Revenue from DOI Cash Fund	(836,200)	(1,082,184)	(1,082,184)	(3,000,568)
Subtotal - Revenue	**$14,163,800**	**$25,617,816**	**($1,082,184)**	**$38,699,432**
General Fund Expenditures				
Transfers to Reinsurance Cash Fund	$15,000,000	$40,000,000	$0	$55,000,000
TABOR obligation vendor fee (OSPB Sept)	15,000,000	40,000,000	0	55,000,000
TABOR obligation Hospital assessment	0	0	0	0
Governor Requested General Fund transfer	0	0	0	60,000,000
Subtotal - Expenditures	**$30,000,000**	**$80,000,000**	**$0**	**$110,000,000**
Net General Fund Cost	**$15,836,200**	**$54,382,184**	**$1,082,184**	**$71,300,568**

SCENARIO 2 – PARTIALLY ACCEPT GOVERNOR'S REQUEST AND MAINTAIN PREMIUM SAVINGS

If the General Assembly wants to maintain the insurance premium reductions targeted in statute and achieved in 2020, it could accept a portion of the Governor's request. The amount from the Governor's request that is needed to eliminate the deficit in state funding is $18.4 million, but in this scenario it also makes sense to eliminate the $13.3 million diversion of insurance premium taxes to reinsurance in FY 2021-22 to allow reinsurance to qualify for enterprise status in that year. If the $13.3 million diversion of insurance premium taxes is eliminated from FY 2021-22, then an equal amount of General Fund needs to be added in FY 2020-21, bringing the total amount of the Governor's request that would need to be approved to $31.7 million. Approving only a portion of the Governor's request would save $28.3 million, eliminating the diversion of insurance premiums would save $13.3 million, and qualifying for enterprise status would save $40.0 million, reducing the total General Fund impact by $81.6 million relative to the Governor's request.

In this scenario, there would be enough funding from state sources in 2021 to maintain the reductions to insurance premiums targeted in statute and achieved in 2020 *under current projections*. There would be

no reserve for contingencies if the projections prove inaccurate. There would be no money prepaid for a potential future extension of the program beyond 2021.

Scenario 2 - Mitigating the General Fund Impact					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	Cumulative
Beginning Balance	$0	$215,000,000	$460,000,000	$250,000,000	
Revenue					
Hospital assessment	40,000,000	0	40,000,000	0	80,000,000
General Fund transfers	15,000,000	40,000,000	0	0	55,000,000
Governor's Request	0	31,700,000	0	0	31,700,000
Insurance premium taxes	0	13,300,000	0	0	13,300,000
DOI Cash Fund for admin	836,200	1,082,184	1,082,184	0	3,000,568
Subtotal - State Sources	*55,836,200*	*86,082,184*	*41,082,184*	*0*	*183,000,568*
Federal Funds	160,000,000	160,000,000	0	0	320,000,000
Total - Revenue	**$215,836,200**	**$246,082,184**	**$41,082,184**	**$0**	**$503,000,568**
Expenditures					
Reinsurance payments	0	0	250,000,000	250,000,000	500,000,000
Administration	836,200	1,082,184	1,082,184	0	3,000,568
Total - Expenditures	**$836,200**	**$1,082,184**	**$251,082,184**	**$250,000,000**	**$503,000,568**
Ending Balance	$215,000,000	$460,000,000	$250,000,000	$0	

General Fund Impact of HB 19-1168 and Related Portions of HB 19-1245 - Scenario 2				
	FY 2019-20	FY 2020-21	FY 2021-22	Cumulative
General Fund Revenue				
Vendor fee (related portion of HB 19-1245)	$15,000,000	$40,000,000	$0	$55,000,000
Diversion of insurance premium taxes	0	(13,300,000)	0	(13,300,000)
Revenue from DOI Cash Fund	(836,200)	(1,082,184)	(1,082,184)	(3,000,568)
Subtotal - Revenue	**$14,163,800**	**$25,617,816**	**($1,082,184)**	**$38,699,432**
General Fund Expenditures				
Transfers to Reinsurance Cash Fund	$15,000,000	$40,000,000	$0	$55,000,000
TABOR obligation vendor fee (OSPB Sept)	15,000,000	40,000,000	0	55,000,000
TABOR obligation Hospital assessment	0	0	0	0
Governor Requested General Fund transfer	0	31,700,000	0	60,000,000
Subtotal - Expenditures	**$30,000,000**	**$111,700,000**	**$0**	**$141,700,000**
Net General Fund Cost	**$15,836,200**	**$86,082,184**	**$1,082,184**	**$103,000,568**

PERFORMANCE OF REINSURANCE

For the projected 223,173 people on the individual market, the Division of Insurance reports that reinsurance reduced premiums by the targeted percentages in the bill. The average premium reduction statewide, from the projected premiums without reinsurance, was $103 per member per month (PMPM), or $1,237 per year. The Division of Insurance did not provide the dollar reduction from the projected 2020 premiums by region, but they did provide the average reduction by region from 2019 premiums. The year over year reduction is smaller than the reduction from the projected 2020 premiums, but it might be a better representation of the impact of reinsurance perceived by consumers, and it shows the variation in experience by region.

Average Decrease in Premiums 2019 to 2020		
Region	PMPM	Annual
Largest targeted reductions		
Region 5 (Grand Junction)	$192	$2,304
Region 9 (West)	$240	$2,880
Middle targeted reductions		
Region 4 (Ft. Collins)	$116	$1,392
Region 6 (Greeley)	$98	$1,176
Region 7 (Pueblo)	$115	$1,380
Region 8 (East)	$181	$2,172
Lowest targeted reductions		
Region 1 (Boulder)	$84	$1,008
Region 2 (Colorado Springs)	$78	$936
Region 3 (Denver)	$82	$984

For consumers with income above 400 percent of the federal poverty guidelines, this is a real reduction in insurance costs. For consumers with income below 400 percent of the federal poverty guidelines, the net impact after accounting for adjustments to tax credits is mixed.

The value of the tax credits is calculated on a sliding scale with the largest tax credits limiting family expenditures for the cost of a benchmark silver plan to 2.0 percent of income and the smallest tax credits limiting family expenditures for the benchmark plan to 9.5 percent of family income. People with incomes below 250 percent of the federal poverty guidelines are also eligible for assistance with coinsurance. Families who purchase insurance that is less expensive than the benchmark silver plan get the same credit.

For anyone buying the benchmark silver plan, the reduction in premium is offset dollar for dollar by a reduction in the tax credit, leaving the consumer paying the exact same percent of income toward insurance. However, for anyone buying a bronze plan, the decrease in the premium is generally going to be less than the decrease in the tax credit, leaving the consumer worse off under the same plan. This is because the average percentage reductions in bonze plans were less than the average percentage reductions in silver plans, and because any given percentage reduction applied to a smaller base for the bronze premium will result in a smaller dollar reduction than the same percentage reduction applied to a higher base for the benchmark silver plan premium.

For these reasons, a large portion of people with income under 400 percent of FPL who buy the same bronze plan in 2019 as 2020 will be worse off under reinsurance. The opposite is true for the 2.6 percent of people below 400 percent of FPL buying gold plans. The Division of Insurance reports the changes in premiums in averages that may hide variations by individual plan. The Division of Insurance emphasizes that in many cases a less expensive plan is available within the same metal level. This appears to be supported by the Division's statistics, but presumably consumers picked their plans for a reason, perhaps related to specific benefits or deductibles or the provider network, and the less expensive options represent a compromise of one or more of the criteria the consumers originally used to make their choice. Not surprisingly, a large portion of people under 400 percent of FPL purchase less expensive bronze plans.

Enrollment by Level under 400% FPL		
Metal Level	Enrollment	Percent
Gold	3,368	2.6%
Silver	68,947	52.8%
Bronze	58,167	44.6%
Total Enrollment <400% FPL	**130,482**	

The Division of Insurance argues that reinsurance allows the state to "leverage" federal funds and achieve a larger reduction in insurance premiums, but the JBC staff is not so sure. The amount of federal funds the state receives is directly related to the amount reinsurance decreases the federal obligation for tax credits for people below 400 percent of FPL. It seems that the federal funds should be roughly equivalent to the cost of buying down the insurance premiums for people below 400 FPL and the state funds should be roughly equivalent to the cost of buying down insurance premiums for people above 400 percent FPL.[2] If this is true, then for a similar state contribution Colorado could implement a more narrowly focused program to benefit people above 400 percent of FPL without needing to get federal pass through funds or potentially harm the 44.6 percent of people below 400 percent of FPL who are buying bronze plans. A more narrowly focused program could take the form of reinsurance for people above 400 percent FPL, or a variation such as state insurance tax credits similar to the federal tax credits for people above 400 percent FPL.

[2] There is some leakage of federal funds as the pass through payments are reduced by 5 percent from the projected decrease in the federal obligation for tax credits, and there might be cases where the reduction in the benchmark silver premium would be more than the reduction in the tax credit for an individual. The amount spent from both federal funds and state sources is less than the decrease in premiums due to administrative costs retained by insurers.